

# SUMMARY OF PAYMENTS

## FATAL CASE

Accident No.

Claim No.

Injured Person

Address

Occupation

Employee

Business

Address

Premiums paid to

Character of Injury

Date of Accident

Actual Weekly Wages \$

Date of Death

### DEPENDENTS

Name of Dependents

Relationship

Date of Birth  
(IF UNDER 18)

### AWARDS OF PAYMENTS

*Compensation*

Payments

% Wages

Amount

Weeks

Total

Remarks

**SEE ATTACHED REVISION**

Total Compensation Payments

### BURIAL AND OTHER EXPENSES

Payment to

For Funeral Expenses

\$

Payment to

For Medical Expenses

\$

Payment to

For

\$

Payment to

For

\$

Total Miscellaneous

\$

Checked

Approved

, 20

CLAIM EXAMINER

Claims Mgr.

Auditor

Member